TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
North Central Surgical Center

Respondent Name
West American Insurance Co

MFDR Tracking Number
M4-16-3644-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting 130% of Medicare DRG with separate reimbursement for implants, plus 10%."

Amount in Dispute: $12,377.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: August 29, 2016 "To date the provider has not submitted all of the required manufacturer invoices to support pricing as the separate implant payment allowable for the REV code 278 with billed charges of $15,110.00 and $3156.00."

August 30, 2016: Invoices were requested but the provider has failed to respond to their requests.

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18 – 19, 2015	Outpatient Hospital Services	$12,377.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for medical services

performed in an outpatient setting.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdiction fee schedule adjustment
   - 1 – This is a packaged item. Services or procedures included in the APC rate, but NOT paid separately
   - 2 – Services reduced to the Outpatient Perspective Payment System (OPPS)
   - W3 – Request for reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 6 – CV: We are unable to complete review of implant charges without documentation of cost or invoices for each implanted item billed

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 16 - "Claim/service lacks information or has submission billing error(s) which is needed for adjudication." 28 Texas Administrative Code §134.403 (g) requires that,

   > Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   >
   > > (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the submitted documentation found no required certification. Therefore the requirements of Rule 134.403 (g)(1) are not met.

2. Based on review of the submitted documentation from both parties, the Division finds additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Peggy Miller	August 31, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.